POSTPARTUM HOME VISIT SUMMARY

MOTHER'S INFORMATION

Patient Name:	Medicaid #:	DOB:	Age:	Race:
Delivery Date:	Type of Delivery:	Delivery Time:	Gestational age @ Delivery:	Hospital D/C Date:
Address:			County:	
Phone Number:	Alternate Phone Number:			
Directions to Home:				

REASON FOR HOME VISIT

(Check all that apply)

___Under 16 years of age ___ Birth weight
___Drugs and Alcohol ___Other: reason
_____
___ Mental Illness ___ No Home Visit Needed

VISIT ATTEMPTS

Date	Type of Attempt

PSYCHOSOCIAL ASSESSMENT

Problems/Issues	YES	NO	Comments
Poor previous parenting experience			
Poor support system			
Literate			
Areas of anxiety noted			
Drugs, Alcohol, Tobacco Usage			
Conflict/ Violence noted in home			
Appropriate newborn/mother attachment			
Support systems present			
Mother able/willing to provide needed infant care			
Father able/willing to provide needed infant care			
Emotional status (Tearful, moody, anxious, depressed)			
Fatigue/Exhaustion			
Sleep disturbances			
Adequate living arrangements			
Other areas of need			
Referrals made			

PHYSICAL ASSESSMENT

Temperature:	BP:		Pulse:	Respirations:
Problems	Yes	No	Comments	
Breasts				
Perineum				
Lochia				
Abdomen (fundus)				
Incision site (signs of infection)				
Edema (location)				
Respiratory status				
Pain				
Appetite/Fluid intake				
Bladder/Bowel Function				

EDUCATION/COUNSELING

Teaching (Check areas discussed/or pamphlets given)

___Breast Care ___Breast Feeding ___Perineum Care ___Hygiene ___Nutrition ___Incision Care ___Bathing

___Family Planning/Birth Control ___Sexual Relations ___Educational Materials/Pamphlets provided ___Other

Comments:

SAFETY ASSESSMENT

___Workable Smoke Detector ___Car Seat Available/Used ___Inside Pets ___Crib Safety ___Telephone ___ Refrigeration ___Adequate Cooling ____ Adequate Heating ___ Vermin infestation
Comments:

Visiting Nurse Signature:	Date of Visit:

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INFANT INFORMATION

Infant name:	___Male ___Female	Birth complications:
Birth weight: Current weight:	___Bottle fed ___Breast fed	___Tolerates Feedings
Formula:	___Ounces every ____Hour ___ Ounces Water per day ___ Wet Diapers per day	___Stools per day
Medications:		
Pediatric Provider:		

INFANT PHYSICAL ASSESSMENT

Temperature:	Heart rate:	Respiratory rate:

Problems		Yes	No	Comments
Skin:	Pink nail beds/Mucous membranes			
	Jaundice			
	Rash			
	Other			
Neurological:	Lethargic			
	Hyper/Hypotonic			
	Crying (high pitched, non-consoling)			
	Symmetrical eye movement			
	Other			
Cardiovascular:	Tachycardia/Bradycardia			
	Irregular heart rate			
	Other			
Respiratory:	Rales/Rhonchi			
	Cough (dry, productive, etc.)			
	Nasal drainage (color, consistency)			
	Other			
Gastrological:	Abdominal distention			
	Other			
Genitourinary:	Abnormal genitalia			
	Circumcision			
	Other			
Extremities:	Adequate bilateral hand grasp			
	Hip click (right or left)			
	Other			

EDUCATION COUNSELING

Teaching: (Check areas discussed or pamphlets provided)
___General Infant Care (bathing, diapering, napping/sleeping position, holding) ___Colic ___Thermometer use ___Danger signs
___Basic Home Safety ___When to call the Doctor ___Normal Growth and Development ___Day Care

Mother's Post Partum Appointment/Date and Time:	Location:	Mother aware:
Infant's next Pediatric Provider Appointment:	Location:	Mother aware:
Other Appointments/Referrals Mother or infant:		

Comments/Address Reason for Home Visit: _____

Visiting Nurse Signature:	Date of Visit